

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

General	Employer (Name & Address incl. zip)				Carrier/Administrator Claim Number		Report Purpose Code									
					Jurisdiction		Jurisdiction Claim No.									
					Insured Report No.											
	NAICS Code				Employer FEIN		Employer's Location Address (if different)		Location No.							
								Phone No.								
Carrier/Claims Admin	Carrier (Name, Address & Phone Number)				Policy Period		Claims Admin (Name, Address & Phone Number)									
					To											
					<input type="checkbox"/>	Check if self insured										
	Carrier FEIN		Policy Number or Self-Insured Number				Administrator FEIN									
Agent Name & Code Number																
Employee	Legal Name (Last, First, Middle)			Birth Date		Social Security Number		Date Hired		State of Hire						
	Address (Incl. Zip)			Sex		Marital Status		Occupation/Job Title								
				<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Unmarried/Single/Div.	<input type="checkbox"/> Married									
				<input type="checkbox"/> Unknown	<input type="checkbox"/> Separated	Employment Status										
	Phone			No. of Dependents		<input type="checkbox"/>	Unknown	NCCI Class Code								
	Wage Rate \$		<input type="checkbox"/>	Day	<input type="checkbox"/>	Month	# Days Worked/WK		Full Pay for Date of Injury?		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No		
			<input type="checkbox"/>	Week	<input type="checkbox"/>	Other	# Hrs Worked per Day		Did Salary Continue?		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No		
Occurrence	Time Employee Began Work		<input type="checkbox"/>	AM	Date of Injury or Illness		Time Occurred		<input type="checkbox"/>	AM	Last Work Date		Date Employer Notified		Date Disability Began	
			<input type="checkbox"/>	PM					<input type="checkbox"/>	PM						
	Employer Contact Name/Phone Number						Type of Illness/Injury				Part of Body Affected					
	Did Injury/Illness Exposure Occur on Employer's Premises?						Yes <input type="checkbox"/>		No <input type="checkbox"/>		Type of Illness/Injury Code				Part of Body Affected Code	
	Department or location where accident or illness exposure occurred						All Equipment, Materials, or Chemicals Employee Using upon Occurrence									
	Specific Activity Employee Engaged in at Time of Occurrence						Work Process the Employee Was Engaged in at Time of Occurrence									
How injury or illness/abnormal health condition occurred. Describe the sequence of events and include any objects or substances that directly injured the employee or made the employee ill.												Cause of Injury Code				
Date Returned to Work				If Fatal, Date of Death				Were Safeguards or Safety Equipment Provided?				<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
								Were they used?				<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
Treatment	Physician/Health Care Provider (Name & Address)				Hospital (Name & Address)				Initial Treatment							
									0 <input type="checkbox"/> No Medical Treatment 1 <input type="checkbox"/> Minor: By Employer 2 <input type="checkbox"/> Minor Clinic/Hosp 3 <input type="checkbox"/> Emergency Care 4 <input type="checkbox"/> Hospitalized – 24 hr. 5 <input type="checkbox"/> Anticipated Major Med/Lost Time							
Other	Signature of Injured Employee, or Signature on File, Date				Witness to Accident (Name & Phone Number)											
	Date Administrator Notified				Date Prepared				Preparer's Name & Title				Preparer's Phone Number			

Filing this report is not an admission of liability. This report shall not be evidence of any fact stated herein in any proceeding in respect of the injury, illness or death on account of which this report is made. Idaho Industrial Commission, P.O. Box 83720, Boise, ID 83720-0041 IC Form IA-1 (08/2013)

**Instructions for Submitting a Workers' Compensation
First Report of Injury or Illness (IC1A-1)**

If you are an insured employer:

Effective November 4, 2017, employers or a representative must submit the First Report of Injury (FROI) in electronic form in accordance with the IAIABC EDI Release 3.0 and the Commission's EDI Guides and Tables. Employers are required to notify their workers' compensation claims administrator for proper filing. It is no longer necessary to forward a paper copy to the Industrial Commission.

If you are an injured worker / injured worker's legal counsel / non-insured employer:

Individual injured workers, injured workers' legal counsel, and employers that are not insured are not required to comply with IAIABC EDI requirements for filing of the FROI. For these individuals, the following instructions apply:

1. The form should be filled out by the uninsured employer or a representative; however, the injured employee may fill out the form if necessary.
2. Fill out non-shaded areas as completely as possible.
3. Distribute copies of the completed form as follows:

- a. The original to:

Idaho Industrial Commission
PO Box 83720
Boise, ID 83720-0041

The .pdf can be emailed to the Commission; however, you must fill out the form, save it under a different name, and then send as an email attachment to froi@iic.idaho.gov.

- b. One copy retained for the employer's/employee's files.
4. The Idaho Industrial Commission will be happy to answer your questions or provide you with helpful brochures on Facts for Injured Workers and Guides for Employers. To obtain this service, please contact the Idaho Industrial Commission at (208) 334-6000; or you may access many of these brochures at www.iic.idaho.gov.